STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

VOLUNTEER STATE HEALTH PLAN, INC.
d\b\a BlueCare and
d\b\a TennCare Select

CHATTANOOGA, TENNESSEE

FOR THE PERIOD JANUARY 1, 2004,
THROUGH DECEMBER 31, 2004

TABLE OF CONTENTS

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DATE: September 8, 2005

A Claims Processing Market Conduct Examination and Limited Scope Financial and Compliance Examination of Volunteer State Health Plan, Inc., Chattanooga, Tennessee, was completed April 21, 2005. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of Volunteer State Health Plan, Inc. (VSHP). Further, this report reflects the results of a limited scope examination of the financial statement account balances as reported by VSHP. This report also reflects the results of a compliance examination of VSHP's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of VSHP was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit, (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement between the State of Tennessee and VSHP (Contractor Risk Agreement), Section 2-15 of the Agreement for the Administration of TennCare Select between the State of Tennessee and VSHP (Administrative Service Agreement), Executive Order No. 1 dated January 26, 1995, and §§ 56-32-215 and 56-32-232 of the Tennessee Code Annotated (Tenn. Code Ann.).

VSHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of VSHP. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statements as reported by VSHP on its

National Association of Insurance Commissioners (NAIC) Annual Statement for the year ended December 31, 2004, and the Medical Fund Target Reports filed by VSHP as of December 31, 2004.

The limited scope compliance examination focused on VSHP's provider appeals procedures, provider agreements and subcontracts; the demonstration of compliance with Federal Title VI of the 1964 Civil Rights Act and the Insurance Holding Company Act.

The fieldwork was performed using records provided by VSHP before and during the onsite examination at the Chattanooga, Tennessee, offices from March 2 through April 21, 2005.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that VSHP's TennCare operations were administered in accordance with the Contractor Risk Agreement, the Administrative Services Agreement and state statutes and regulations concerning HMO operations, thus reasonably assuring that the VSHP TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether VSHP met its contractual obligations under the Contractor Risk Agreement and the Administrative Services Agreement and whether VSHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq*. and Tenn. Code Ann. § 56-11-201 *et seq*;

- Determine whether VSHP had sufficient financial capital and adequate risk reserves to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether VSHP properly adjudicated claims from medical service providers and made payments to providers in a timely manner;

- Determine whether VSHP had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether VSHP had corrected deficiencies outlined in prior reviews of VSHP conducted by the Comptroller or examinations conducted by TDCI.

III. PROFILE

A. Administrative Organization of VSHP

Volunteer State Health Plan II, Inc. (VSHP II), a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee, Inc. (BCBST), was chartered as a for-profit corporation in the State of Tennessee on July 1, 1996, for the purpose of providing managed health care services to individuals participating in the state's TennCare Program in all community service areas except the Knox County and East Tennessee community service areas. On November 8, 1996, by way of the Articles of Amendment to the Charter, VSHP II changed its name to Volunteer State Health Plan, Inc.

On January 1, 1998, VSHP merged with Volunteer State Health Plan-Eastern Tennessee, Inc., (VSHP-ET), a not-for-profit corporation also wholly-owned by BCBST. VSHP-ET was a licensed HMO that participated in the TennCare Program in the Knox County and East Tennessee Community Service Areas. VSHP was the surviving corporation after the merger was completed. After the merger of VSHP and VSHP-ET, VSHP provided coverage to TennCare enrollees on a statewide basis.

The officers and board of directors for VSHP at December 31, 2004, were as follows:

Officers for VSHP

Ronald Ellis Harr, President & CEO
David Lee Deal, Treasurer & CFO
John Linville Shull, Secretary
Harold Hoke Cantrell, Jr., Assistant Treasurer
Shelia Dian Clemons, Assistant Secretary

Board of Directors for VSHP

Ronald Ellis Harr	Vicky Brown Gregg
David Lee Deal	Joan Carol Harp

B. Brief Overview

Effective November 4, 1996, TDCI granted VSHP II (later VSHP) a certificate of authority to operate as a TennCare HMO. Thereafter, VSHP began operating as a statewide MCO in the TennCare program. VSHP operated this line of business under the plan name BlueCare.

Effective July 1, 2001, VSHP's contract with the TennCare Bureau limited BlueCare enrollment to the Eastern Grand Region. Also effective July 1, 2001, VSHP entered into the Administrative Services Agreement with the TennCare Bureau to administer a safety net plan called TennCare Select. Under this agreement, the state, and not VSHP, is at risk for the cost of medical services. TennCare Select provides services for children in state custody or at risk of being placed in state custody; children that are Social Security Income eligible; children receiving services in an institution or under the State's Home and Community Based Service waiver; and TennCare enrollees residing out of state. Furthermore, TennCare Select has received additional enrollment from MCOs with terminated TennCare contracts. These enrollees remain in TennCare Select until the Bureau of TennCare determines if the remaining contracted TennCare MCOs are able to accept additional enrollees.

VSHP's BlueCare plan is currently authorized by TDCI and the TennCare Bureau to participate in the TennCare program in the Eastern Grand Region. VSHP's TennCare Select program operates statewide.

VSHP derives the majority of its revenue from payments from the state for providing medical benefits to TennCare enrollees. As of December 30, 2004, VSHP had 258,408 BlueCare members and 456,500 TennCare Select members according to the TennCare Bureau's enrollment report.

Effective July 1, 2002, the Contractor Risk Agreement was amended for BlueCare to temporarily operate under a no-risk agreement for medical costs. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the Bureau of TennCare in restructuring the program design to better serve Tennesseans adequately and responsibly. BlueCare agreed not to make any change to the reimbursement rates, reimbursement policies and procedures, and medical management in effect on April 16, 2002, unless such changes received approval in advance by the Bureau of TennCare.

During the stabilization period, VSHP receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to BlueCare. The TennCare Bureau reimburses VSHP for the cost of providing covered services to TennCare enrollees.

C. Claims Processing Not Performed by VSHP

VSHP is responsible for the processing of all medical claims for assigned enrollees with the following exceptions:

- Dental
- Pharmacy
- Behavioral Health

TennCare has contracted with other organizations for the processing of these types of services. During the period under examination, VSHP processed all other claims internally.

IV. PREVIOUS EXAMINATION FINDINGS

TDCI and Comptroller Examination

The following were claims processing and internal control deficiencies cited in the examination by the Tennessee Department of Commerce and Insurance, TennCare Division, for the period January 1, 2002, through December 31, 2002:

1. For one of the 20 TennCare Select claims tested, a claim was processed using an incorrect price resulting in an incorrect payment.

2. For one of the 20 TennCare Select claims tested, the copayment was incorrectly applied.

3. A subcontract reviewed did not include all of the required Title VI language.

None of the deficiencies listed above are repeated as part of this report.

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Financial Deficiencies

1. Administrative Expenses as reported on the Underwriting and Investment Schedule - Part 3, were not allocated in accordance with Statutory Accounting Principles Number 70. (See Section VI.A.3)

B. Claims Processing Deficiencies

1. VSHP did not process claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1), Section 2-18. of the Contractor Risk Agreement, and Section 2-9.7.b of the Administrative Services Agreement for the month of October 2004. (See Section VII.A)

C. Compliance Deficiencies

1. The documentation maintained to support the data in the provider appeal log was not adequate for several appeals selected for testing. (See Section VIII.A)

2. The provider dispute log did not indicate the received date of the provider disputes. (See Section VIII.A)

3. For the three provider contract tested, VHSP was unable to verify that all amendments to the contracts were executed in accordance with provision outlined in the provider contracts themselves and in the Contractor Risk Agreement and the Administrative Services Agreement. As a result, the examiners could not verify that the executed provider agreements reviewed correspond to the provider agreements templates approved by TDCI. (See Section VIII.C)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, VSHP is required to file annual and quarterly statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed in these reports to determine if VSHP meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting

differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At December 31, 2004, VSHP reported $37,254,193 in admitted assets, $6,237,101 in liabilities and $30,017,092 in capital and surplus on its 2004 NAIC Annual Statement. VSHP reported a net loss before income tax of $3,091,570 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires VSHP to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are included in the calculation of net worth and deposit requirements.

2005 Statutory Net Worth Calculation

VSHP's premiums per documentation obtained from the TennCare Bureau totaled $1,543,550,627 for the calendar year 2004; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), VSHP's current minimum statutory net worth requirement is $26,903,259. VSHP reported total capital and surplus of $31,017,092 as of December 31, 2004, an excess of $4,113,833 above the statutory requirement.

Premium Revenue for the Examination Period

For the examination period January 1 through December 31, 2004, the following is a summary of VSHP's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

BLUECARE

Administrative fee payments from the TennCare Bureau for the period January 1 through December 31, 2004	$41,339,627
Reimbursement for covered services from the TennCare Bureau for the period January 1 through December 31, 2004	478,610,360
Reimbursement for premium tax payments from the TennCare Bureau for the period January 1 through December 31, 2004	10,467,767
Prior year capitation payments from the TennCare Bureau received during the period January 1 through December 31, 2004 for dates of service July 1, 2001 through June 30, 2002	(124,102)

TENNCARE SELECT

Administrative fee payments from the TennCare Bureau for the period January 1 through December 31, 2004	$69,882,557
Reimbursement for covered services from the TennCare Bureau for the period January 1 through December 31, 2004	924,092,098
Reimbursement for premium tax payments from the TennCare Bureau for the period January 1 through December 31, 2004	19,282,320
Total premium receipts for the period January 1 through December 31, 2004	$1,543,550,627

2. R

estricted Deposit

Tenn. Code Ann. § 56-32-212(b)(3) requires all HMOs licensed in the state to maintain a deposit equal to $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a) (2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan."

Based upon premium revenues for calendar year 2004 totaling $1,543,550,627, VSHP's statutory deposit requirement at December 31, 2004, is $8,950,000. VSHP has on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $8,950,000 have been pledged for the protection of the enrollees in the State of Tennessee.

3. Management Fee

BCBST provides administrative services for the BlueCare and TennCare Select plans. The fee paid to BCBST for administrative services is based on a management agreement approved by TDCI.

During the examination period January 1, 2004, through December 31, 2004, the BlueCare and the TennCare Select lines of business were paid monthly fixed administrative fees by the TennCare Bureau in exchange for administrative services for VSHP per Section 2.9.e.1 of the Contractor Risk Agreement and Section 4-1.1(d) of the Administrative Services Agreement. This fixed administrative fee along with the net investment income earned by VSHP is paid to BCBST by BlueCare and TennCare Select for administrative services. It should be noted that interest earned on ASO funds is the property of the state and is not forwarded to BCBST.

For NAIC financial statement reporting, the management fee must be apportioned to the administrative expense categories defined on NAIC annual and quarterly financial statements. The NAIC 2004 Health Quarterly and Annual Statement Instructions require that an HMO that has paid management fees to an affiliated entity "shall allocate these

costs to the appropriate expense classification item (salaries, rent, postage, etc.) as if these costs had been born directly by the company…The reporting entity may estimate these expense allocations based on a formula or other reasonable basis."

The NAIC's Statement of Statutory Accounting Principles No. 70 requires that these expenses be further allocated to three general categories – claims adjustment expense, general administrative expense, and investment expense. Allocation to these categories "should be based on a method that yields the most accurate results." Specific identification of an expense with an activity that is represented by one of the categories will generally be the most accurate method. Where specific identification is not feasible allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analysis."

For allocating the management fee paid by VSHP to BCBST to expense classifications on the Underwriting and Investment Exhibit – Part 3 of the NAIC Annual Statement, VSHP used percentages derived from the administrative expenses BCBST reported by line item on its 2004 NAIC Annual Financial Statement. VSHP did not provide supporting documentation that the percentages used to allocate the management fee reflected expenses as if these costs had been borne by VSHP itself.

After allocating the management fee to administrative expense classifications, on the Underwriting and Investment Schedule Exhibit – Part 3, VSHP allocated the administrative expense classifications into the three administrative categories based on a pro-rata percentage of administrative expenses as reported on BCBST's 2004 NAIC Annual Statement. This allocation method is inconsistent with the SSAP 70 requirement set forth above.

VSHP should review its methodology for the apportioning management fees to NAIC administrative expense classifications and categories. As discussed in the NAIC 2004 Health Quarterly and Annual Statement Instructions and Statutory Accounting Principle No. 70, VSHP should allocate management fees to expense classifications as if these costs had been borne by VSHP itself and to then allocate expenses to administrative categories first by specific identification. If specific identification is not possible, then allocation based on percentages is acceptable. Documentation should be maintained to support that the allocation methodology is reasonable and yields the most accurate

results.

Any change to the current allocation methodology will not affect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expenses on the Underwriting and Investment Exhibit – Part 3 of the NAIC financial statements.

MANAGEMENT'S COMMENTS

Volunteer State Health Plan (VSHP) as a reporting entity, pays BlueCross BlueShield of Tennessee (BCBST) for the management, administration and reviewing of all VSHP business operations. The cost of operations paid to BCBST is reported on the "Underwriting and Investment Exhibit Part 3-Analysis of Expenses" in the appropriate expense classification as if these costs had been borne directly by VSHP. This basis is described in the NAIC annual statement instructions.

BCBST's "Underwriting and Investment Exhibit Part 3-Analysis of Expenses" serves as the basis for allocating the VSHP expense payments to the appropriate expense classification. BCBST expenses by expense category are used to create each expense classification excluding categories not applicable to the VSHP functional operations like advertising, marketing, broker commissions, etc. The resulting percentages are applied to the VSHP administrative expense to calculate the dollar amount by line item. The dollar amount by line item is also allocated to the cost containment, other claim adjustment, and general and administrative columns based on the respective corporate percentages. BCBST's expenses are reviewed at a divisional level to develop the percentages. The claim and cost containment expenses are specifically identified to calculate the respective percentage. The remaining percentage is then used for the general administrative column.

Functional units that support all of BCBST's operations incur a large majority of VSHP's administrative expenses. Because costs directly borne by dedicated operational areas are such a small percentage of VSHP's total costs, BCBST's expense categories are the most accurate basis for reporting VSHP expenses.

We believe that this methodology is compliant with the NAIC's Statement

of Statutory Accounting Principles No. 70, requiring costs to be allocated using a "method that yields the most accurate results."

Rebuttal by TDCI

The method to allocate costs utilized by VSHP is not a method that yields the most accurate results. The method utilized by VSHP assumes that all of the plans administered by BCBST would incur administrative expenses in the same proportion for the expense categories defined on the Underwriting and Investment Exhibit – Part 3. As discussed in the NAIC 2004 Health Quarterly and Annual Statement Instructions and Statutory Accounting Principle No. 70, VSHP should allocate management fees to expense classifications as if these costs had been borne by VSHP itself and to then allocate expenses to administrative categories first by specific identification. An example of costs that can be specifically identified as paid by BCBST is salaries. Cost of employee salaries whose duties are 100% related to VSHP would be a cost specifically identified as borne by BCBST for VSHP and thus first allocated to VSHP. Cost of employees whose duties which are related to more than one of the plans administered by BCBST would be allocated to each plan on an applicable percentage such as study of employee activities.

4. Claims Payable

As part of the NAIC Annual Statement filing requirements, each MCO is required to provide a statement of actuarial opinion. This statement expresses an opinion on whether the claims payable reported by the MCO is adequate to cover all future obligations. This statement must be prepared by a member of the American Academy of Actuaries. VSHP's statement was prepared by its actuarial department and met all the requirements established by the NAIC. The actuarial statement supported a claims payable amount of $0. This amount agreed with the amount reported on the NAIC balance sheet as "Claims Unpaid."

It should be noted that the claims payable amount discussed above relates only to the BlueCare plan for medical services performed prior to July 1, 2002. Pursuant to statutory accounting principles, an accrual for claims unpaid is not to be booked for BlueCare after June 30, 2002, or for TennCare Select since they were operating as administrative service organizations not at risk for medical services.

B. Administrative Services Only (ASO)

As previously mentioned, VSHP has not been at financial risk for the cost of medical claims incurred by the TennCare Select line of business since its inception in July 2001. Effective July 1, 2002, VSHP's Contractor Risk Agreement was amended so that BlueCare would also operate at no financial risk for the cost of medical claims until December 31, 2003. The stabilization period has since been extended to December 31, 2005.

These types of arrangements are considered "administrative services only" (ASO) by the NAIC. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet for TennCare Select for the entire year and BlueCare for dates of service after July 1, 2002.

The Contractor Risk Agreement requires a deviation from ASO guidelines. The required submission of the supplemental TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if VSHP were still operating at risk. Section 2-10.i. of the Contractor Risk Agreement requires VSHP to provide "an income statement addressing the TennCare operations." VSHP provided this information on the Supplemental TennCare Operations Statement, Report 2A.

C. Medical Fund Target

Effective July 1, 2002, the Contractor Risk Agreement required VSHP to submit a Medical Fund Target (MFT) report monthly. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for IBNR claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT report. VSHP submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for expenses incurred but not reported have been reviewed for accuracy.

No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Fund Target reports.

D. Schedule of Examination Adjustments to Capital and Surplus

There were no examination adjustments to capital and surplus.

VII. DETAIL OF TESTS CONDUCTED

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether VSHP pays claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1), Section 2-18. of the Contractor Risk Agreement, and Section 2-9.7.b of the Administrative Services Agreement. The statute mandates the following prompt pay requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are processed, and if appropriate paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the

remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI had previously requested data files from all TennCare MCOs containing all claims processed during the months of January 2004, April 2004, July 2004, and October 2004. Each set of data was tested in its entirety for compliance with the prompt pay requirements of Tenn. Code Ann. If a TennCare MCO fails to meet prompt pay standards, TDCI will analyze claims data monthly until the MCO achieves compliance.

Medical Results – BlueCare

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2004	98.79%	99.94%	**Yes**
April 2004	99.03%	99.94%	**Yes**
July 2004	98.38%	99.95%	**Yes**
October 2004	96.92%	98.04%	**No**
November 2004	97.04%	99.5%	**Yes**

Medical Results – TennCare Select

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2004	99.02%	99.97%	**Yes**
April 2004	98.90%	99.93%	**Yes**
July 2004	98.59%	99.94%	**Yes**
October 2004	96.78%	98.11%	**No**
November 2004	94.12%	99.5%	**Yes**

VSHP processed claims timely in accordance with the requirements for the months of January, April and July 2004. VSHP did not process claims timely for the month of October 2004. VSHP explained that its failure to meet prompt pay requirements in October 2004 was due to the upgrade of its claims processing system. VSHP was required to submit claims data for November 2004 and was found to be in compliance with the prompt pay requirements for that month.

MANAGEMENT'S COMMENTS

Per the response to TDCI on December 2, 2004, 60-day timeliness was slightly under the goal due to the following reason:

Analysis of Claims Processed in October in 2004

Your analysis found that BlueCare processed 98.04% and TennCare Select processed 98.11% of claims within 60 days. In late September, we identified a print problem involving a a small subset of our CMS-1500 claims. We determinded the problem began on April 15, 2004. Prior to this date, these claims were printing to the worksheets and the claims were then manually adjudicated by our claims processing department. On April 15th, a change was made that stopped the printing of this subset of claims. A total of 29,613 claims for both BlueCare and TennCare Select were not printed before the problem was corrected. After the claims were identified, they were adjudicated as a priority in October to ensure providers received payment as soon as possible. The majority of the claims were processed within the month of October, which resulted in both BlueCare and TennCare Select not meeting the 60-day goal. Additionally, due to some claims requiring manual intervention, a small number were adjudicated the first week of November.

We are confidant the system problem has been corrected, and the following actions have been implemented, or are in process, to ensure this issue will not re-occur:

- Formed an internal workgroup to re-evaluate current controls involving claims routing.
- Updated current documentation available to the Support (Mail) department to reflect the additional control steps implemented (i.e. workflow process to be monitiored on a daily basis).

We are evaluating the current system configuration to determine the possibility of systematic adjudication of these claims thus eliminating the need for a manual process.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of test work to be performed in testing VSHP's claims processing system.

TDCI reviewed the following items to determine the risk that VSHP had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints on file with TDCI related to accurate claims processing
- Results of TDCI's prompt pay testing
- Results reported on the claims payment accuracy report submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims payment accuracy reports
- Review of internal controls

TDCI's review of these systems and controls revealed no significant deficiencies. VSHP attributed its failure to meet the prompt pay requirements of Tenn. Code Ann. § 56-32-226(b) to the claims processing system conversion. Therefore, TDCI did not expand substantive testing.

C. Claims Payment Accuracy Report

Section 2-9. of the Contractor Risk Agreement requires that 97% of claims be paid accurately upon initial submission. VSHP is required to submit a claims payment accuracy report 30 days following the end of each quarter.

VSHP reported the following results for the examination period:

BLUECARE	Claims Tested	Results Reported	Compliance
First Quarter 2004	1734	99.5%	**Yes**
Second Quarter 2004	1844	99.7%	**Yes**
Third Quarter 2004	1750	99.3%	**Yes`**
Fourth Quarter 2004	1512	99.7%	**Yes**

TENNCARE SELECT	Claims Tested	Results Reported	Compliance
First Quarter 2004	2430	99.3	**Yes**
Second Quarter 2004	2736	99.5%	**Yes**
Third Quarter 2004	2675	99.6%	**Yes**
Fourth Quarter 2004	2676	99.4%	**Yes**

1. Procedures to Review Claims Payment Accuracy Reporting

   The review of the claims processing accuracy report included an interview with staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the fourth quarter 2004 claims payment accuracy report. This review included verification that the number of claims tested by VSHP constituted a statistically valid sample.

   In addition, TDCI and the Comptroller randomly selected 20 claims for each line of business from VSHP's fourth quarter 2004 claims payment accuracy report. These claims were reviewed to determine if the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation traced directly to the actual report filed with TennCare.

2. Results of Review of the Claims Payment Accuracy Reporting

   The quarterly claims payment accuracy report for the fourth quarter of 2004 was selected for review. TDCI and the Comptroller judgmentally selected 20 claims for testing that were identified by VSHP as correctly paid. Also, all claims identified in the report with errors were reviewed to ensure the errors had been corrected. No deficiencies were noted in VSHP's testing of the 40 claims reviewed by TDCI and the Comptroller.

D. <u>Claims Selected For Testing</u>

TDCI and the Comptroller selected 60 claims from each line of business for testing. From previous prompt pay testing by TDCI, VSHP had provided data files of claims processed for the months of January, April, July, October, and November 2004. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment. From the combined data files, 60 claims were selected for each line of business using a random number generator.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of non-compliance within the total population of claims.

To ensure that the data files included all claims processed in the month, the total amount paid per each data file was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in the claims processing system. Attachment XII of the Contractor Risk Agreement lists the minimum required data elements to be captured from medical claims and reported to TennCare as encounter data. Original hard copy claims were requested for the 60 BlueCare claims and 60 TennCare Select claims tested.

The data elements of Attachment XII recorded on the claims selected were compared to the data elements entered into VSHP's claims processing system. No discrepancies were noted when comparing the data on the 120 claims to the data entered into VSHP's claims processing system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. A review of all 120 claims revealed no deficiencies.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly. Ten claims were selected for each line of business to test. A review of the 20 claims and their corresponding executed provider contracts revealed no deficiencies.

H. Withhold and Copayment Testing

The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. VSHP's contracts with providers do not apply withhold to provider payments.

The purpose of testing copayments is to determine whether enrollees are subject to out-of-pocket payments for certain procedures, within liability

limitations, and if out-of-pocket payments are accurately calculated in accordance with Section 2-3.K. of the Contractor Risk Agreement and Section 2-4.11 of the Administrative Services Agreement.

VSHP supplied TDCI the top 100 copay accumulator report for each line of business. This report identifies the 100 enrollees who have the highest copayment accumulated as of the date of the report. The top 10 enrollees were selected from each list to test for the proper accrual of copayments. For all 20 claims tested, the copayments were properly accumulated and coordinated with dental and mental health copayments.

I. Explanation of Benefits (EOB) Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to copayments are provided an explanation of benefits in accordance with usual and customary health care industry practices.

VSHP provides EOBs to all enrollees. VSHP provided copies of the EOB sent for all 60 claims tested for each line of business. No discrepancies were noted in the information provided on the EOB when compared to information in the claims processing system.

J. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to the provider accurately reflect the processed claim information in the system.

The remittance advices for 10 of the 60 claims tested for each line of business were requested to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the information communicated to the providers on the remittance advices.

K. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to verify the actual payment of claims by VSHP and to determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The cancelled checks for claims tested above in remittance advice testing were requested. The check amounts agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

L. Pended Claims

The purpose of testing pended claims is to determine the existence of claims that have been suspended or pended by VSHP, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. VSHP provided the examiners a pended claims report as of February 21, 2004. VSHP reported a total of 8,686 pended claims of which none were over 60 days old. The review of the pend file did not indicate a potential material unrecorded liability.

M. Electronic Claims Capability

Section 2-9.g. of the Contractor Risk Agreement states, "The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment...." Section 2-2.h. of the Contractor Risk Agreement required MCOs to move to electronic billing. Sections 2-1(i) and 2-9.7(b) of the Administrative Services Agreement impose these requirements on TennCare Select. Electronic billing allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II ("HIPAA") required that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

VSHP has implemented the changes necessary to process claims per the standards outlined in the HIPAA statutes. VSHP is currently processing claims under these standards for some of their providers.

N. Mailroom Testing and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures followed by VSHP ensure that all claims received from providers are either returned to providers where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included observation of actual procedures. Mailroom and claims inventory controls were adequate.

Ten claims were selected from a batch of incoming mail on March 3, 2005, to determine if the claims were entered into the claims processing system with correct received dates. All ten claims were entered into the claims processing system with correct received dates.

VSHP's claims inventory controls reconcile all claims received from providers. The claims are either returned to the provider where appropriate or processed by the claims processing system.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Complaints, Appeals and Disputes

The purpose for testing provider complaints and appeals is to determine if VSHP responds timely and if VSHP has developed policies and procedures for resolving complaints and appeals. VSHP's provider administration manual provides comprehensive instructions for filing complaints, appeals and disputes.

Complaints

VSHP classifies a provider's first contact about a problem as a complaint. If the complaint is in writing, VSHP responds in writing to the provider. If the complaint is a telephone call, VSHP tries to resolve the problem immediately. VSHP documents and logs all complaints in a database. VSHP's goal is to resolve 90% of complaints within 7 days and 100% of complaints within 21 days.

From a list of provider complaints received during the examination period, the examiners selected three BlueCare complaints and three TennCare Select complaints. All of the six complaints were telephone calls. VSHP provided screen prints from its database for each complaint. All six complaints had the

required data fields: date received, nature of the dispute, responsible party, if appropriate, resolution indicator and resolution date. Of the complaints reviewed, five were resolved on the day they were received and one complaint was resolved the following day.

Appeals

VSHP classifies as appeals those complaints that are in writing and include documentation from the provider. Utilization Management processes appeals dealing with issues related to medical necessity as opposed to administrative issues such as claims adjustments. These appeals are logged into a separate database. VSHP's provider manual states that VSHP will respond to appeals within 21 days of the receipt of the appeal.

From the appeals log provided by VSHP, the examiners selected three BlueCare appeals and three TennCare Select appeals and requested the supporting documentation. The provider appeals logs included the required data elements, including date received, date resolved, resolution and other pertinent information. The following deficiencies were noted for the appeals selected for testing:

- The documentation for one appeal did not support the received date or the resolved date reported in the log.

MANAGEMENT'S COMMENT

We acknowledge the discrepancy and we are taking steps to correct it.

- Three appeals did not have documentation to support the received date reported in the log.

MANAGEMENT'S COMMENT

We acknowledge the discrepancy and we are taking steps to correct it.

- For one appeal, the log indicated a 21-day turnaround time, but the documentation indicated a 28-day turnaround time.

MANAGEMENT'S COMMENT

We acknowledge the discrepancy and we are taking steps to correct it.

Provider Disputes

Provider appeals regarding administrative and reimbursement issues are classified as provider disputes. From VSHP's provider dispute log, examiners selected eight provider disputes for testing. The provider dispute log did not indicate the received date for any of the disputes selected for testing.

MANAGEMENT'S COMMENTS

We actually do capture and track the received date of provider disputes. However, we did not include the received date as a data element in the report that we provided to TDCI during the audit. That was an oversight on our part and we will take steps to ensure that it does not re-occur in the future.

B. Provider Administration Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. VSHP's submits updates to its provider manuals to TDCI for approval on a quarterly basis. The most recent approval was submitted to the Compliance Section of the TDCI TennCare Division on February 2, 2005 and was subsequently approved on February 10, 2005.

C. Provider Agreements

Pursuant to Tenn. Code Ann. § 56-32-203(b)(4), agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO. The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to, standards of care, assurance of TennCare enrollees' rights, compliance with all Federal and State laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the Contractor Risk Agreement, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division of the Department of Commerce and Insurance in accordance with applicable statutes. Additionally, Section 2-18 of the Contractor Risk Agreement and the Administrative Services Agreement require that all provider agreements executed by VSHP include the requirements listed in Section 2-18.

Three provider agreements related to claims tested were reviewed to determine if they agreed to the approved provider template on file with TDCI.

Section 2-18.cc of the Contractor Risk Agreement requires the following be included in all provider agreements:

> Specific procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments to be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

All three agreements tested included terms which allowed VSHP to amend the agreement via notification to the provider. The terms of the agreements allow the providers at least thirty (30) days to accept or reject the amendment.

A provider agreement file folder was provided to the examiners for the three agreements selected for testing. The folder included the core agreement, TennCare network attachments and their subsequent amendments. These documents were compared to the approved templates on file with TDCI. In all three cases, the items found in the provider agreement file folders did not always contain the approved version of the core agreement, the approved network attachments and/or all approved amendments. For example the provider agreement file folder for the group practice contract tested contained the BCBST Group Practice Agreement version 1. The approved contract should have been using version 3. There was nothing in the provider agreement file folder to indicate that the core agreement had been updated with the necessary amendments to bring the agreement in compliance with version 3. Further, some of the documents in the provider agreement file

were neither signed by the provider nor included required "receipt of notification of amendments" to demonstrate that the agreement was properly amended.

Upon notification that the files appeared incomplete, VSHP provided TDCI additional amendments not included in the original provider files reviewed. The additional documents provided were neither signed by the provider nor included the required "receipt of notification of amendments." There was no evidence provided that these new documents had been delivered to the providers or that they were allowed at least 30 days to accept or reject the amendments.

Since no evidence was provided to the examiners to document that the provider had been informed of the amendments, the examiner could not verify that the amendments had actually been properly executed. As a result, the examiners could not verify that the executed provider agreements reviewed correspond to the provider agreement templates approved by TDCI.

MANAGEMENT'S COMMENTS

The audit report indicates that, upon review of the contracts, VSHP did not always have appropriate versions of the Core Agreements, approved network attachments and/or approved amendments. The example referenced was the Group Specialist Contracts.

As a follow-up to the initial TDCI review, a packet was mailed via certified mail to the TDCI Auditor, Robin Lowe, containing all correct and accurate agreement versions and amendments as indicated in the spreadsheet. In addition, all notification letters and amendments were included in the packet.

The audit report stated that some of the amendments were not executed or signed, nor did they include a "receipt of notification of amendments" to demonstrate that the amendments were properly executed.

We acknowledge the discrepancy and will make sure this information is included in the future.

D. Provider Payments

Examiners tested capitation payments to providers during January 2004 to determine if VSHP had complied with the payment provisions set forth in its provider agreements.

All capitation payments during January 2004 were made timely in accordance with the approved provider agreements.

E. Subcontractors

With the exception of the administrative services agreements with BCBST as described in section VI.2, during the examination period, VSHP did not subcontract any of the major provisions of the Contractor Risk Agreement or the Administrative Services Agreement.

F. Title VI Compliance Testing

Effective July 1996, Section 2-24 of the Contractor Risk Agreement and Section 2-24 of the Administrative Service Agreement require VSHP to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various VSHP staff and a review of policies and related supporting documentation, VSHP was in compliance with reporting requirement of Section 2-24 of the Contractor Risk Agreement and Section 2-24 of the Administrative Services Agreement.

G. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…" VSHP has complied with this statute.

H. Contractual Requirements for ASO Arrangements

As previously mentioned, VSHP has operated the TennCare Select line of business as an ASO product since its inception in July 2001. Effective July 1,

2002, VSHP's Contractor Risk Agreement was amended so that BlueCare would operate as an ASO as well. While the provisions tested below have always been a requirement for TennCare Select, they only are effective for BlueCare transactions with dates of service after July 1, 2002.

1. Medical Management Policies

Section 2-2.s of the Contractor Risk Agreement requires VSHP to comply with the following as they relate to the BlueCare line of business:

> Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as that existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for the purpose of documenting medical management policies and procedures before final execution of this Amendment.

Section 5-2.1 of the Administrative Services Agreement requires VSHP to comply with the following as they relate to the TennCare Select line of business:

> Providers shall be paid according to BlueCare policies and procedures and reimbursement rates in effect as of March 1, 2001, unless otherwise directed by TennCare.

VSHP's management has confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations to the requirements for BlueCare and TennCare Select were noted.

2. Provider Payments

Section 3.10.h.2(b) of the Contractor Risk Agreement states that VSHP "shall release payments to providers within 24 hours of receipt of funds from the State." The first check run issued in December 2004 was selected for testing. The funds were traced to the bank deposit as received and to an email correspondence to the custodian of the checks

instructing him to release the checks on the same day. VSHP has complied with this provision.

3. 1099 Preparation

Section 3-10.h.2(c) of the Contractor Risk Agreement and Section 5-3.b. of the Administrative Service Agreement state that VSHP "shall prepare and submit 1099 Internal Revenue Service reports for all providers to whom payment is made." VSHP was able to provide a reconciliation of provider payments to the total reported to the IRS via 1099 reports. VSHP also demonstrated compliance by providing a copy of its receipt from the electronic transmission of the 1099s to the IRS on February 23, 2005.

4. Interest Earned on State Funds

Section 3-10.h.2 (d) of the Contractor Risk Agreement and Section 5-3.c of the Administrative Services Agreement state interest generated by funds on deposit for provider payments related to the no-risk agreement period shall be the property of the State. By tracing amounts reported as interest received per bank statements to invoices submitted to the TennCare Bureau, it was determined that VSHP had remitted to the State interest earned on deposits for provider payments related to the no-risk agreement period.

5. Pharmacy Rebates

Section 3-10.h.2(e) of the Contractor Risk Agreement and Section 5-3..d of the Administrative Service Agreement state that pharmacy rebates collected by VSHP shall be the property of the state. Pharmacy rebates collected in 2004 were traced to subsequent invoice to TennCare as a reduction in the amount to be received.

6. Recovery Amounts/Third Party Liability

Section 3-10.h.2(f) of the Contractor Risk Agreement and Section 5-3.e of the Administrative Services Agreement state third party recoveries and subrogation amounts related to the no-risk agreement period be reduced from medical reimbursement requests to the TennCare Bureau. VSHP reduced medical reimbursement requests to the TennCare Bureau for the amounts recovered from third parties.

I. Conflict of Interest

Sections 4-7. of the Contractor Risk Agreement and Section 6-7. of the Administrative Services Agreement warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to VSHP in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

VSHP demonstrated the following efforts to determine compliance with Conflict of Interest clauses of the Contractors Risk Agreement:

- The administrative service agreements between BCBST and VSHP for BlueCare and TennCare Select include the same conflict of interest language as the Contractors Risk Agreement.
- Provider Agreements contain the conflict of interest language of the Contractors Risk Agreement.
- BCBST employees complete conflict of interest questionnaire/disclosure statements.
- The organizational structure of BCBST includes a Chief Compliance Officer who reports directly to the Board of Directors and the Board Audit Committee.
- BCBST has an internal audit department which monitors day-to-day compliance issues as well as the performance of focused audits of Contractors Risk Agreement requirements.
- Standards for ethical guidelines have been formalized in a Code of Business Conduct for employees.
- A written compliance program has been developed to provide a mechanism to enforce the Code of Business Conduct. The compliance program includes, but is not limited to, the duties of the Chief Compliance Officer, auditing processes, and the reporting of violations.

VSHP and the administrative subcontractor, BCBST, have developed procedures to determine compliance with conflict of interest requirements of the Contractor Risk Agreement. No instances of non-compliance of Contractors Risk Agreement conflict of interest requirements were noted during examination test work.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of VSHP.